Battle Plan Training: Module 1

Control of Combat Stress

Battle Plan Training Objectives

- The Battle Plan Training modules were developed:
  - To establish a structured training program for all Division Mental Health Section members;
  - To clarify the DMHS's tactics, techniques and procedures in Combat Stress Control operations.

Module 1 Objectives

- What is Stress?
- What is Combat Stress?
- What are Combat Stress Behaviors?
- Combat Stress Control
- Principles of Combat Psychiatry
- Further Treatment Principles for Battle Fatigue

Additional Resources

- During review of this Module, consult *Field Manual 8-51, Combat Stress Control in a Theater of Operations, Chapter 1.*

- The following resources may also prove helpful:
  - *FM 22-51, Leaders' Manual for Combat Stress Control*
  - *FM- 8-55, Planning for Health Service Support*

What is Stress?

- Stress is the body's and mind's process for dealing with uncertain change and danger.
- Stress can have positive and negative effects on functioning.
  - Positive Effects can enhance performance.
  - Negative Effects can impair overall functioning.

What is Combat Stress?

- The art of war aims to impose so much stress on the enemy soldiers that they lose their will to fight.
- Combat Stress is often the deciding factor--the difference between victory and defeat--in all forms of conflict.

Types of Combat Stress

- Physical
  - Environmental
  - Physiological
- Mental
  - Cognitive
  - Emotional

- Physical and Mental stressors are often inseparable.

Examples of Physical Combat Stressors

Environmental

- Heat, Cold, Wet
- Difficult Terrain
- Poisonous Area
- Physical Work
- Ionizing Radiation
- Noise, Vibration
- Visibility

Physiological

- Sleep Debt
- Dehydration
- Poor Hygiene
- Physical Fatigue
- Illness and Injury
- Malnutrition

Examples of Mental Combat Stressors

Cognitive

- Information (Too much/little)
- Sensory (Too much/little)
- Time (Pressured vs Waiting)
- Rules of Engagement
- Unit Dynamics
- Isolation, Ambiguity
- Choice (Too much/little)

Emotional

- Threats to Safety
- Loss, Bereavement
- Anger, Frustration
- Boredom, Inactivity
- Homefront Worries
- Loss of Faith
- Interpersonal Conflict

Combat Stress

- Elimination of stress is both impossible and undesirable.
- Stress may lead to Combat Stress Behaviors.
- Controlling stress is key to controlling these resultant behaviors.

What are Combat Stress Behaviors?

- Adaptive Behaviors
- Dysfunctional Behaviors
  - Misconduct Stress Behaviors/Criminal Acts
  - Battle Fatigue

Examples of Adaptive Combat Stress Behaviors

- Unit Cohesion
- Sense of Eliteness
- Alertness and Vigilance
- Increased Strength and Endurance
- Tolerance for Hardship, Pain, Discomfort
- Heroic Acts and Self Sacrifice

Examples of Dysfunctional Combat Stress Behaviors

Misconduct

- Mutilating Dead
- Torture, Brutality
- Recklessness
- Looting, Rape
- “Fragging”
- Desertion
- Abuse of Sick Call

Battle Fatigue

- Hyperalertness
- Fear, Anxiety, Panic
- Anger, Rage
- Somatic Complaints
- Depression, Indecision
- Exhaustion, Apathy
- Poorer Performance

Combat Stress Control (CSC)

- Unit Commanders are ultimately responsible for CSC.
  - They are assisted by their NCOs, chaplains, medical personnel, general/principal/special staff, CSC units, and mental health personnel.
- Division Mental Health Section's role will be discussed throughout these Battle Plan Training Modules.

3 Principles of Combat Psychiatry

- Maximize Combat Stress Prevention
- Treat Battle Fatigue
- Defer Psychiatric Diagnosis

- Combat experiences during this century support these general principles.
  - *Read FM 8-51, 1-9 through 1-11 for details.*

#1 Maximize Combat Stress Prevention

- Primary Prevention
  - Decreases the occurrence of Dysfunctional Combat Stress Behaviors.
- Secondary Prevention
  - Minimizes Dysfunctional Combat Stress Behaviors when they first occur.
- Tertiary Prevention
  - Minimizes long term Dysfunctional Combat Stress Behaviors and Post Traumatic Stress Disorder.

Primary Prevention

- Control stressors known to increase Dysfunctional Combat Stress Behaviors:
  - First time in combat
  - Home front worries
  - Intense battle with many killed/wounded
  - Insufficient tough/realistic training
  - Poor unit cohesion
  - Sleep/Food deprivation
  - Inadequate information or no clear sense of purpose

Secondary Prevention

- Train leaders, chaplains, and medical personnel to:
  - Identify warning signs and symptoms
  - Intervene immediately
  - Prevent spread of dysfunctional behavior through segregation and treatment.
  - Reintegrate recovered Battle Fatigue soldiers into their units.
  - Taking appropriate disciplinary action for criminal conduct.

Tertiary Prevention

- Training leaders, chaplains, and medical personnel in the following:
  - Critical Event Debriefings
  - End of Tour Debriefings
  - Continued monitoring for delayed Post Traumatic Stress Disorder symptoms.

#2 Treat Battle Fatigue

- Proximity
  - Treat soldier as close to their unit and battle as possible.
- Immediacy
  - Treat as soon as possible.
- Expectancy
  - Give the positive expectation for full recovery and return to duty.
- Simplicity
  - Use brief, straightforward methods to restore physical well-being and self-confidence.

#3 Defer Psychiatric Diagnosis

- Triage emergency medical/surgical conditions and then treat.
- Treat others for Battle Fatigue using the PIES plan (seen on previous slide).
- Non-responders should be evacuated to a higher level of care. Final diagnosis is determined at this level.

Further Treatment Principles for Battle Fatigue

- Initial Assessment
  - Brief medical and mental status examination
  - Triage is key
    - Battle Fatigue vs more emergent illnesses:
      - For example surgical, medical, neuropsychiatric, drug and alcohol abuse, and head/trunk injuries.
  - Treat for Battle Fatigue while covertly observing for other more serious conditions.

Treatment Principles Continued

- Reassure
  - Tell the soldier that he has Battle Fatigue and that it is a temporary condition.
  - Explain that BF is not cowardice or illness, but a normal reaction to severe conditions. Remember: Battle Fatigued soldiers are not called *patients.*
  - Give expectations that he will return to duty after a short period of rest.
  - Keep the soldier active.

Treatment Principles Continued

- Separate
  - Keep BF soldiers separated from patients with serious medical, surgical and psychiatric illnesses.
  - Association with the severely ill will worsen BF soldiers' symptoms (called *contagion*).
  - Convalescent soldiers and BF soldiers may be treated together after the *contagious* stage is over and return to duty is imminent.

Treatment Principles Continued

- Simple Treatment
  - Keep treatment as simple as possible.
  - Use the PIES treatment plan.
  - PIES treatment should be applied to soldiers receiving treatment for other injuries/illnesses.
  - Provide relief from danger but maintain a tactical atmosphere which is not too comfortable.

Treatment Principles Continued

- Restore Confidence
  - Keep soldiers active through structured military work details, physical exercise, and recreation.
  - Get soldiers to talk about their experiences that led to Battle Fatigue.
  - Provide supportive environment for self expression.
  - Reinforce soldier's identity as a soldier, not as a *patient*.

Treatment Principles Continued

- Avoid Sedatives and Tranquilizers
  - The BF soldier needs to maintain a normal state of alertness, coordination and understanding.
  - Sedating medications may be used if sleeplessness or agitation cannot be otherwise managed.
  - Remember: The soldier will think that medications are used by *patients*.

Treatment Principles Continued

- Evacuation and Hospitalization
  - Evacuate and hospitalize BF soldiers only when absolutely necessary.
  - Evacuation and hospitalization may significantly worsen initial symptoms and delay recovery.
  - Evacuate by general-purpose vehicles not ambulances (land/air).
  - Only the Division Psychiatrist approves evacuations from the Division (AR 40-216).

Treatment Principles Continued

- Unmanageable Cases
  - A soldier whose BF or Neuropsychiatric symptoms make him too disruptive to manage may be evacuated to the next echelon of care.
  - Prior to evacuation, give the soldier a clear expectation that he will improve.
  - Be careful not to let “unmanageability” become an escape route from combat.

Treatment Principles Continued

- Unresponsive to Initial BF Treatment
  - A BF soldier may be sent to the next echelon of care if he does not respond to initial treatment.
  - This soldier needs to be given clear expectations for recovery before evacuation.
  - Do not let “unresponsiveness to treatment” become an escape route from combat.

Treatment Principles Continued

- Hospitalization
  - Use when the BF soldier's safety is uncertain.
  - Non-hospital environments are preferable to hospitalization.
  - If a soldier is inappropriately hospitalized, inform him that he only has BF that he will be returned to a forward area for treatment.

Treatment Principles Continued

- Restoration and Reconditioning
  - Two programs designed to provide trials of treatment within the combat zone and the communications zone (COMMZ).
  - BF casualties are not evacuated to CONUS without having one or both of these treatment trials.

Treatment Principles Continued

- *Restoration* is a treatment program:
  - conducted in the Division combat area;
  - provided by the medical attachment, CSC and/or DMHS;
  - lasts 1-3 days;
  - restores the BF soldier's combat skills.

  - In the corps area, Restoration is conducted by the medical detachment, CSC and/or the mental health section of the ASMB.

Treatment Principles Continued

- *Reconditioning* is a treatment program:
  - conducted in the Corps combat area and COMMZ;
  - provided by the medical company, CSC;
  - Requires a hospital admission (for account-ability), but conducted in a non-hospital environment;
  - lasts 7-14 days;
  - restores the BF soldier's combat skills.

Exit

Conclusion

- Stress is an inevitable part of combat which can both benefit and harm soldiers.
- Control of combat stress can maximize a soldier's adaptive combat stress behaviors and minimize the dysfunction behaviors.
- DMHS plays an important role in the prevention and treatment of dysfunctional combat stress behaviors.
- Treatment Principles provide a guideline to provide efficient care to Battle Fatigue casualties.